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In the Supreme Court of the United States

OCTOBER TERM, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AND BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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1. Respondents devote the first half of their brief in opposition (at 2-15) to an argumentative restatement of the facts. Two aspects of that restatement call for a brief response.

a. First, respondents argue (Br. in Opp. 4-8) that the Secretary did not promulgate the final regulations at issue in this case until 1989, and that those regulations "completely changed" (*id.* at 5) the implementation of the Medicare Secondary Payer (MSP) program. Respondents offer no support, however, for their claim (*id.* at 7) that the 1989 regulations "reversed" any prior interpretation by the Secretary of the MSP statute. Indeed, the Secretary had articulated her view that the statute overrides contrary

private contractual provisions as early as 1983. See Pet. 8. The 1989 regulations were issued, as respondents acknowledge (Br. in Opp. 7-8), because of the Secretary's disappointment with the degree of voluntary compliance with what she had previously regarded—and continues to regard—as the statute's "complete and clear" requirements. Compare 53 Fed. Reg. 22,335 (1988) (promulgating final regulations) with 50 Fed. Reg. 28,989 (1985) (announcing initial decision not to issue specific regulations interpreting 1984 MSP amendments).

The regulations at issue are interpretive, not legislative, rules. Cf. Pet. App. 24a-26a. They could not, and did not, "expan[d] the class of entities legally and financially liable" (Br. in Opp. 7) under the MSP program. All they did was to express in "crisper and more detailed" terms (Pet. App. 25a) the Secretary's view that the class of such entities includes third-party administrators (TPAs), and that each entity remains "required or responsible under [the statute] to pay * * * under a primary plan," even if the Secretary does not receive "notice or other information" about that responsibility until after a private contractual claims-filing deadline has already passed. 42 U.S.C. 1395y(b)(2)(B)(i) and (ii) (Supp. IV 1992). With respect to the validity of the regulations, the issue is not when the Secretary expressed her interpretations of the Medicare Act, but whether those interpretations are reasonable. If they are, then the 1989 regulations validly "elucidat[e] * * * rights and duties created by Congress" (Pet. App. 25a) to which respondents have been subject since the enactment of the MSP provisions.

b. Respondents likewise attempt to divert attention from the issue at hand by questioning (Br. in Opp. 9-12) the Secretary's method of administering the MSP provisions—and, indeed, the entire Medicare payment mechanism. Thus, respondents argue (*id.* at 11) that the Secretary would not need to seek repayment from them under the regulations at

issue if she "would simply determine whether private coverage exists *before* making a payment" to any provider or beneficiary on any claim. In fact, the Secretary does require providers and beneficiaries to supply information on private coverage when filing claims, and claims are not paid where it appears that primary private coverage exists. See, *e.g.*, 42 C.F.R. 489.20(f); C.A. App. 307-310.

Monitoring the accuracy of private coverage information supplied by tens of thousands of providers (who may not themselves be aware of private coverage) and millions of beneficiaries (essentially all of whom are elderly or disabled) is not, however, as "simple" as respondents imply. The Secretary has concluded, as a matter of administrative policy, that facially valid claims by or on behalf of Medicare's beneficiaries should in general be paid promptly, despite the knowledge that later review will disclose that the primary coverage information supplied with some of those claims was inaccurate or incomplete. That judgment—clearly contemplated by Section 1395y(b)(2)(B)(i)'s explicit provision for payments "conditioned on reimbursement * * * when notice or other information [concerning primary coverage] is received"—is one for the Secretary, not for respondents. And the issue in this case is whether the statute provides for the recovery of such conditional payments from respondents, not whether respondents would prefer a different method of collection.

2. Respondents attempt to defend (Br. in Opp. 15-19) the court of appeals' decision that the Secretary is bound by the claims-filing limitations of private group health plans, which are otherwise required to provide coverage primary to Medicare. As we explain in our petition (at 17), the court's grammatical analysis of the statute (Pet. App. 16a-17a; compare Br. in Opp. 16-17) is at best inconclusive, and we will not revisit that issue here. Respondents suggest no satisfactory answer, however, to the Secretary's arguments

(Pet. 17-20) based on the structure and history of the statutory scheme.

As the petition points out (at 17), claims-filing limitation problems typically arise because of the practical problems that Medicare encounters in collecting pertinent information about private health coverage. Because facially valid claims are often presented and paid before complete and accurate information is available, Medicare must be able to recover those payments when it is able to confirm that they should instead have been paid by a private plan. The MSP statute accommodates that need through Section 1395y(b)(2)(B).

It takes a substantial amount of time, however, to collect and confirm coverage information—which plan operators and administrators, including respondents' members, have so far been unwilling to provide to the Secretary voluntarily. Indeed, the elaborate Data Match program that Congress enacted in 1989 to strengthen compliance with the MSP provisions explicitly contemplates the collection and use of coverage information that is three or more years old. See Pet. 19-20. Because of such time lags, private claims-filing deadlines will frequently have run by the time the Secretary receives the "notice or other information" about private coverage that triggers the Secretary's right to recover under Section 1395y(b)(2)(B). Thus, respondents' reading of the statute effectively vitiates both the statutory right of recovery and the Data Match program, and insulates respondents' members from the liability Congress intended them to bear.

Respondents contend (Br. in Opp. 17-18) that because facially valid claims are typically paid by Medicare before private plan deadlines would have expired, "it is hard to see why the government's recovery efforts would be time-barred." That argument is disingenuous. The critical date for purposes of a putative private claims-filing limitation is not the date that Medicare pays a claim, but the date that the

Secretary demands payment from the private plan. That date, in turn, depends on when Medicare learns that the private plan is primarily liable, which is also the date on which the Secretary's right of recoupment arises under Section 1395y(b)(2)(B).

Similarly, respondents essentially ignore the central significance of the Data Match program. See Pet. 7-8, 19-20, 26-27. Their only response (Br. in Opp. 18-19) is that Congress's expectation that the Secretary would recover overpayments identified through Data Match from responsible parties "according to existing rules" could not refer to the claims-filing limitation override regulation at issue here, because that regulation was not finally adopted until two months after publication of the relevant committee report. That argument ignores the fact that the regulation was proposed more than a year earlier. 53 Fed. Reg. 22,335 (1988); see Pet. 9. That proposal, and the extensive public comment that addressed it (see 54 Fed. Reg. 41,716 (1989)), formed part of the background against which Congress created Data Match in 1989. In any event, as noted above (at 1-2) and in the petition (at 8), the regulation only embodied the Secretary's longstanding interpretation that the MSP statute itself overrides contrary private contractual provisions.

3. With respect to the liability of TPAs, respondents concede (Br. in Opp. 19-20) that Judge Williams found the relevant statutory language ambiguous. They defend (*id.* at 20-23) his decision not to defer to the Secretary's resolution of that ambiguity because he thought her interpretation not "necessary to accomplish Congress's goals" (Pet. App. 10a), despite his acknowledgment (*ibid.*) that the Secretary's construction of the statutory language "would be reasonable" if he thought her policy justifications stronger. Yet respondents make no serious attempt to dispute the practical reasons for TPA liability identified in the petition. Compare Pet. 22-23 & nn.15-16 with Br. in Opp. 20. And even if they

could, the exercise would be beside the point. As Chief Judge Mikva recognized in his dissent on this point (Pet. App. 38a), if the statutory language is ambiguous and the administrative construction a permissible one, related judgments of policy (particularly those based on the "operational realities" (*id.* at 36a) of a complex federal benefits scheme) are committed to the discretion of the Secretary, not the courts. See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984); *Thomas Jefferson Univ.* v. *Shalala*, 114 S. Ct. 2381, 2387 (1994).

4. As the petition makes clear (at 23-26), the decision below raises novel and important issues concerning the degree of deference to be accorded to agency interpretive rules, and whether any deference should be accorded "retroactively" when an agency or court applies the underlying statute to conduct predating formal promulgation of the agency's interpretation. Respondents' attempt to downplay the significance of that issue rests entirely on the Secretary's supposed "concession" that the general prohibition of retroactive rulemaking announced by this Court in *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988), "applies equally to 'legislative' and 'interpretative' rules." Br. in Opp. 23. Respondents rely on the court of appeals' imputation to the government, without citation, of an "implicit concession" to the same effect. See Pet. App. 25a. But the Secretary has never made such a concession, implicit or otherwise.

To the contrary, the government's brief in the court of appeals explicitly argued (at 47-48) that "[t]he issue of 'retroactive rulemaking' that the courts have dealt with in cases * * * such as [*Georgetown*] involves altogether distinct considerations," precisely because in legislative rules an agency "imposes obligations or standards" under general statutory direction, whereas interpretive rules of the sort at issue in this case "simply state the Secretary's authoritative interpretation regarding recovery rights *that are already*

express in the statute." Respondents' reliance on *Georgetown* is no response to that position, which we set forth again in the petition (at 23-24). And respondents' failure to advance any more persuasive argument suggests the indefensibility of the court of appeals' holding.

5. Respondents contend that, even if the decision below is wrong, it is not sufficiently important to warrant this Court's review. See, *e.g.*, Br. in Opp. 2, 15. Their brief fails, however, to refute the reasons we have identified for review by this Court.

Beyond suggesting that the Secretary wait (perhaps for years) to pay any Medicare claim until she can be certain that there is no primary private coverage (Br. in Opp. 9-11), respondents do not answer the reasons given in the petition (at 18, 22-23, 26-27) why invalidation of the two regulations at issue here will have a serious negative impact on the administration of the Medicare program. Similarly, although respondents assert (Br. in Opp. 8) that the Secretary's estimates of the very substantial monetary impact of the decision below have "no basis in fact," they offer no explanation of why those estimates—which are based, as the petition makes clear (at 26-27), on the Secretary's actual experience with the first round of the Data Match program—might not be trustworthy.

Nor do respondents suggest persuasive reasons why the errors below concerning the proper review of administrative interpretations under *Chevron*, and the deference to be accorded to interpretive rules (as distinguished from legislative rules or agency interpretations adopted through adjudication) with respect to transactions occurring prior to their promulgation, do not merit review. Those errors have implications for the activities of every federal administrative agency, and they were made by the court in which "the vast majority of challenges to administrative agency action are brought." *Vermont Yankee Nuclear Power Corp.* v. *Natural*

Resources Defense Council, Inc., 435 U.S. 519, 537 n.14 (1978).[1]

Respondents embrace (Br. in Opp. 27) our contention (Pet. 27-29) that, because the decision below is a declaratory judgment in the District of Columbia Circuit, in a case involving parties whose members represent a large proportion of the private health insurance industry and the majority of significant TPAs, it is unlikely to be practical or efficient for the Secretary to litigate the issues involved in other circuits. Since the date of our petition, litigation against Blue Cross Blue Shield of Michigan (BCBS Michigan), which was then pending in a district court in the Sixth Circuit (see Pet. 28 & n.19), has been settled, on terms that require a payment of $24 million to the government in settlement of past MSP claims. Importantly, the settlement in that case also imposes on BCBS Michigan an ongoing obligation to provide the Secretary with coverage data that will enable her to identify more quickly and efficiently those Medicare claims as to which BCBS Michigan may be the appropriate primary payer. We continue to believe that it would be inadvisable for the Secretary to forgo otherwise prudent settlements simply in order to preserve any remaining opportunity to litigate the threshold regulatory issues in other circuits—or for this Court to forgo consideration of the questions presented by the petition in this case, which involves the bulk of the private

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[1] The court of appeals' decision on retroactivity has already been followed, without independent discussion, by one district court in a different circuit. *United States* v. *Blue Cross Blue Shield of Michigan*, 859 F. Supp. 283, 286 n.4 (E.D. Mich. 1994). Cf. *National Treasury Employees Union* v. *Federal Labor Relations Authority*, 30 F.3d 1510, 1514 (D.C. Cir. 1994) (discussing effect of later administrative interpretation on prior judicial construction); *Capital Network System, Inc.* v. *FCC*, 28 F.3d 201, 205 (D.C. Cir. 1994) ("[i]n some sense * * * review of an agency's construction of an ambiguous statute is review of the agency's policy judgment[s]," quoting Pet. App. 8a).

insurance industry, in anticipation of additional lower-court litigation against individual parties. See Pet. 28-29.

6. Finally, respondents mention (Br. in Opp. 12) discussions among respondents and the Secretary related to the issues in this case, apparently with the implication that review should be denied because of the prospect of a negotiated settlement. The Secretary would be pleased if the parties could reach an agreement that the Secretary could conclude would, on balance, make it unnecessary to pursue this case further.[2] And we would, of course, inform the Court promptly if any such agreement were reached. Unless and until such an agreement is reached, however, the existence of discussions among the parties does not affect the importance of the issues involved in this case, their significance to the Secretary's ability to enforce the MSP provisions as Congress intended them to be enforced, or the need for this Court's resolution of the questions presented.[3]

* * * * *

[2] Because settlement by the parties would not, in itself, result in this Court vacating the judgment below, see *U.S. Bancorp Mortgage Co.* v. *Bonner Mall Partnership*, 115 S. Ct. 386 (1994), the Secretary would have to consider not only the effect of settlement on the parties to this litigation, but also the continuing effect of the judgment on the Secretary's ability to enforce the MSP statute against non-parties. It is partly for that reason that discussions with the parties have also included, as respondents point out (Br. in Opp. 12), the possibility that a settlement (if reached) might include "the joint submission to Congress of the legislative changes needed" to ensure that uniform rules apply to all insurers and TPAs.

[3] Indeed, respondents' suggestion that the Court deny review because some settlement discussions have occurred while the case is in its current posture ignores the fact that a denial of certiorari would, by rendering the judgment below final, greatly alter whatever "settlement" calculus might then remain.

For the foregoing reasons, and those set forth in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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Solicitor General

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